

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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EDITORIAL

I have made a short calculation, on good data, and estimate that twenty thousand guineas are annually paid by parents and guardians of medical students in order that a quarter of a million golden hours of youth may be wasted by compulsion in listening to feeble matter vilely delivered.

The Student's Guide to the Medical Profession by C. B. Keetley.

ONE often hears comparisons between the conditions of today and the conditions prevailing in an analogous society a generation or more ago. It is not unusual for parents to draw on their inevitably misty and biased memories and contrast their own generation with that of their children with most unfavourable results. The youth of today are considered to be irresponsible as to their behaviour and their attitude to money, to show a lack of politeness and an inability to entertain themselves. The children are thought by the parents to be more noisy and infinitely more expensive than they themselves were as children. However is it the children that have changed for the worse or is it the environment in which they have flourished that has changed and in particular has the environment in which the modern generation of Bart's medical students exist altered from that of twenty years ago?

Comparisons at any time are invidious but on occasions must be made and it is fair to ask at the beginning of 1958 whether Bart's like Punch is not so good as it was. One can easily take any arbitrary standpoint to justify whichever answer one elects to choose but nevertheless the proposition bears careful

analysis before a fair assessment can be made.

On the credit side of the account the magnificent new buildings which have been erected at Charterhouse Square must head the list. The provision by the Medical College and London University of teaching and research laboratories, lecture theatres, and a College Hall which are unsurpassed by any similar projects in the other teaching hospitals of the country was indeed a piece of great and commendable foresight. To stay with the static improvements to the teaching facilities of the hospital one must include the new wing now nearing completion in Little Britain. This will vastly improve the opportunities for the student body to study the diagnosis, treatment and special nursing measures necessary in the highly specialized departments which are to be installed there. Also the provision of a new nurses' home to accommodate the nurses from Hill End will allay some students' fears of "while the cat's away" since no longer will there be twenty-odd miles of well-nigh impassable country between them.

It is indeed regrettable that whilst so much money has been spent in creating a Sub-

Utopia at Charterhouse Square for the pre-clinical students that no real efforts have been made to improve the teaching facilities at the hospital itself. The lecture theatre destroyed by enemy bombing in the war has not been replaced and the present clinical lecture theatre was first built as a dissecting room and now manifests the cold discomforts which are only too befitting for a dissecting room. The laboratories are obsolete, dark and uncomfortable.

Such are the changes which have, and have not, taken place on the face of Bart's but the real revolution has taken place beneath the surface of the hospital. The old relationship between students and the teaching staff seems to have been sacrificed vicariously on the altar of the Education and National Health Acts. Once so much an integral part of the soul of the hospital, based on respect and affection on the one part and humility and devotion on the other it has passed out of the life of the hospital and has been replaced by the unrelenting quest of the student body as a whole for appointments to the House from the very moment of their arrival at the Hospital. This is of course a local reflection of a national problem but is nonetheless regrettable for all that.

With the changing attitude of the student and the profession as a whole to the criteria necessary to a successful start to a medical career so the attitude of authority has changed. No longer is the undergraduate allowed any latitude in satisfying a large number of requirements before qualifying, not least amongst them being the compulsory attendance at certain lectures. This compulsion deprives the student of the exercise of what personal integrity he has, since no account is taken of the quality of the lecturer.

If medicine is to be considered as a subject which of its very nature is fascinating and absorbing in spite of the unfortunate presentation of the subject by a man who finds it difficult to carry his meaning across, then no lecture need be compulsory since they will be attended nonetheless. If conversely any lecture fails to be absorbing either in subject or in presentation then it has no right to be compulsory.

This gradual transition from a University College concerned with more than just producing doctors to a highly specialised technical school is perhaps the most regrettable change of all. Inevitably the breadth of vision enjoyed by the student becomes

narrowed and his quest for knowledge stultified. There is something to be gained for Bart's if a compromise between the '*laissez faire*' attitude of older and well tried systems of undergraduate education and the needs of the ever-increasing scientific demands of medicine could be arranged. A completely '*laissez faire*' attitude would not be possible but a compromise should, or indeed, must be found.

Punch has managed to change its standards and modify its frames of reference with the times and has not lost its charm, its tradition nor its erudition. Bart's has changed and is still changing, posterity alone can judge to what. Perhaps in twenty or so years' time we too will look at our Hospital and nod sadly, saying "Bart's isn't what it used to be . . ." and then, remembering, say "Or is it?"

The View Day Ball

For the first time for many years the Senior Secretary of the Students' Union has been able to face an A.G.M. of the Union and publicly announce that apathy is no longer his *bête noire*. This was, however, not the only unusual feature of the meeting. The proposals of last year's Ball Committee to hold this year's View Day Ball in a marquee on the College Hall lawns came under fire, and the discussion lasted well over an hour, becoming somewhat acrimonious by the end.

The reasons for changing the venue for the ball are somewhat specious in quality. Firstly, there is no suggestion that there will be any financial advantage in holding it in a tent as compared to an hotel, but that the novelty of dancing on the lawns at Charterhouse Square will draw at least the same support as a ballroom at the Park Lane Hotel.

Whether in fact the idea that people who have long since forsaken the Hospital will find the new proposal attractive and come to the dance is one which can only be decided by experience. If, however, the dance is not a success, people who normally come will not be prepared to support it in later years.

In any case, the problem is to decide for whose enjoyment the Ball is primarily in-

tended—the Past or the Present. If the latter, then the incentive to spend a quite considerable amount of money on a ticket is partly the opportunity to live for a few hours in surroundings to which they are unaccustomed.

It is, indeed, strange to hear that the traditional View Day Ball is to be held at the end of June, when View Day itself is on the second Wednesday in May. By the same token, the Ward Shows could well be held at the end of January, when the whole spirit of Christmas has disappeared. Perhaps an alternative name for the ball could be "The Students' Union Midsummer Madness".

The Dramatic Society

In the last week of November the Dramatic Society performed Ronald Jean's "Count Your Blessings" on the stage of the Cripplegate Theatre before an audience of encouraging magnitude. One must applaud their choice of play, for comedies, though more difficult to perform, are more palatable to an audience which is familiar with the players. Only one setting was required and this must have been a boon to the stage-manager and his assistants. The society is indeed fortunate to have, in John Sugden and his helpers, gentlemen who are prepared to give their time and energies to behind-the-scenes work.

This play has two long and exacting parts for the young husband and wife who are beset with financial difficulties. The most arduous task fell to Miss Jean Arnold and after a rather shaky start she rose nobly to the occasion. Her voice lacked flexibility for such a long part but it had a pleasant tone and carried well into the theatre. Victor Major mastered the part of the young husband extraordinarily well and gave an extremely polished display. If one can criticise his performance at all it is only to comment that his love scenes with his wife lacked ardour by medical student standards.

On the first night Miss Nancy Watts fidgeted in the wings as her entry cue in the first act was passed over and she failed to appear until the next scene. However, such an experienced campaigner as Miss Watts was not to be denied and on the second night she appeared to a warm ovation from the

audience who were rewarded with an effusive and invigorating performance.

Peter Fenn achieved the correct note of superciliousness as the expectant brother-in-law, although his pseudo-Oxford accent tended to slip into the Bart's bedside baritone; but perhaps this was intentional. Miss Gillian Smith succeeded in arousing our sympathy for poor Charles Edward, whilst Miss Francis Aitkin made a succulent P.G. siren and some gentlemen in the audience were distinctly disappointed that the negligé of the script was replaced by a rather tomboyish pair of pyjamas. After his display as a mixed-up mid-European politician one expects any weekend to find Brian McGrath mounted on a soap-box in Hyde Park, though I fear he will quickly lose his sympathisers unless he becomes more audible. Miss Janice Swallow, well padded for the occasion, made a convincing char.

The audience as ever at the Cripplegate were willing to laugh in the wrong, but mainly in the right, places and one felt that all the cast might have profited by allowing the laughter to subside somewhat before proceeding. Such occasions have a notorious reputation for being a pleasure only to the cast and their relations and the society are to be congratulated for really entertaining their supporters. The evening was pleasantly rounded off by a brief curtain speech from the producer, Miss Dawn Watling, after which, Mr. Capps, the president of the society, presented flowers to the ladies and, thinking himself one bouquet short, gallantly kissed the lady concerned only to find more flowers produced from the wings. Altogether it was a most enjoyable evening and one can only wish that all amateur productions were of an equally high standard.

Overseas Scholarships

Over 100 scholarships are being offered to British students by 19 foreign countries for study abroad during the academic year 1958-59. They are mainly for university graduates and undergraduates, but some are open to candidates with non-academic qualifications.

The scholarships generally provide for free tuition and maintenance and most of them are tenable for a full academic year,

though there are a number of awards for shorter periods.

The countries offering the scholarships are: Austria, Belgium, Brazil, Denmark, Finland, France, Germany, Iceland, Iran, Italy, Japan, The Netherlands, Norway, Poland, Portugal, Spain, Sweden, Switzerland and Yugoslavia. Most of the scholarships correspond to awards made by the British Council to students from these countries for study in the United Kingdom.

The British Council assists in publicising the offers and in most cases in the recruitment of candidates. Closing dates for applications vary according to the country concerned, the earliest being 1st February, 1958.

Further information and application forms, for which a stamped, addressed foolscap envelope should be sent, can be obtained from any British Council office, or from the Director, Universities Department, The British Council, 65, Davies Street, London, W.1.

The Boat Club Dinner

Strains of "Poor Little Angeline" and similar bawdy songs echoing around Smith-



"Helping hands"?

field at midnight on the last Wednesday in November should have indicated to any informed observer that the serious business of the Boat Club's annual dinner had just been concluded and that the frivolities were about to begin.

This year the dinner was held at the Rutland Hotel, West Smithfield, and this new venture proved an unqualified success. The club is indeed deeply indebted to Mr. Richford for the quality of the food and service and for the modest charge made to the fifty members present. The choice of wines, spirits or beer to be served with the meal was popular. During the dinner and at the post-prandial celebrations Mr. B. R. Collier was busy taking photographs, and the club will, we hope, repay his efforts by buying as many prints as possible.

The Guest of Honour this year was Mr. Charles Kindersley, who travelled up from Bath at the club's invitation. He was formerly secretary and captain of the Club, and also played Rugby Football for the 1st XV. In those far-off days the Boat Club consisted of only four members, one Blue and three trial caps; little wonder then that they should have carried off the United Hospitals' Trophy.

In proposing the toast to the guests, Mr. Bowles said that Mr. Kindersley claimed to be the only man ever to be suspended by his ankles from the gallery of the Empire, Leicester Square, and survive the experience. He then went on to welcome the other guests who were the Warden, Messrs. Peter Bell and Tim Edwards, from London Rowing Club, Mr. Morris and Mr. R. M. Phillips. Also present was Dr. Michael Taylor, of the Physiology Department, who is assisting the club in the design of a rowing tank. The first fruit of this project, a working model built to scale, was on display.

Mr. Kindersley then made a brief and witty reply and concluded by exhorting the members to enjoy themselves, as he felt that riotous youth led to responsible maturity. Professor Garrod, the President, then proposed the Boat Club, and Mr. Besser in his reply made the customary survey of results and prospects. In the Winter Regatta, four of the Hospital's boats raced in finals, but only the Rugger Club's IV could achieve victory. He concluded that the overall position was very encouraging.

New Addresses

Mr. Frankis Evans, 115, Chertsey Road, Twickenham, Middlesex.

Dr. Gunaratnam Cooke, Kerimalai, Kankasanthurai, Ceylon.

Dr. P. M. Goodrich, 3, The Ridings, East Preston, Sussex.

Journal Staff

Mr. J. K. Chong has resigned as editor of the *Journal*.

Mr. M. J. L. Patterson has been appointed editor of the *Journal*.

ANNOUNCEMENTS

Engagements

PLUMPTRE-PRISTON.—The engagement is announced between Martin Plumptre and Alison Priston.

TREHARNE-MERWOOD.—The engagement is announced between Philip Gordon Treharne and Hermione Ann Merwood.

Births

IVENS.—On November 10, 1957, to Daphne, wife of Dr. Hugh Ivens, a son (Paul Michael), a brother for Hilary and Christopher.

JENKINS.—On November 15, to Elizabeth and Dr. George Jenkins, a son (Mark Andrew).

ROGERS.—On November 26, to Mary, wife of Dr. David Rogers, a daughter.

TODD.—On November 10, to Jean, wife of Ian P. Todd, a son (Steuart).

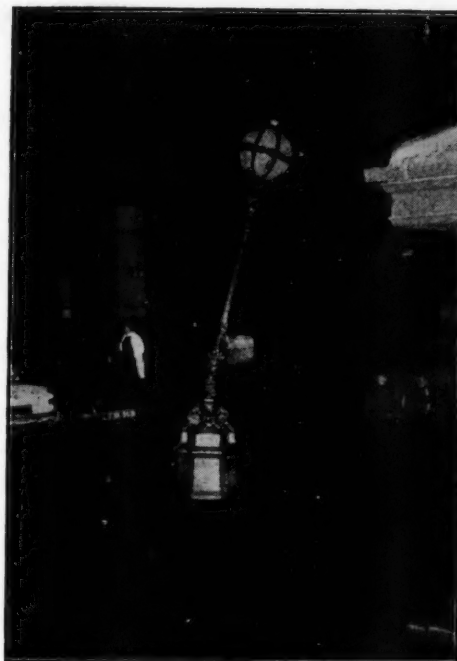
Deaths

COLT.—On October 26, George Herbert Colt, aged 79, Qualified 1904.

HANCOCK.—On October 25, Frank Thompson, aged 76. Qualified 1908.

MOORE.—On November 13, Charles Gordon Moore, C.V.O., aged 72. Qualified 1910.

WILSON.—On October 7, Ambrose Cyril Wilson. Qualified 1908.



"Odd leanings"

CALENDAR

Sat. 11th.—Dr. G. Bourne and Mr. J. B. Hume on duty.

Anaesthetist: Mr. F. T. Evans.

Soccer: v. Old Chigwellians **H.**

Hockey: v. National Provincial Bank **H.**

Wed. 15th.—Soccer: v. Charing Cross and Royal Dental Hospital 'A' XI **A.**

Sat. 18th.—Dr. A. W. Spence and Mr. C. Naunton Morgan on duty.

Anaesthetist: Mr. R. A. Bowen.

Soccer: v. St. Thomas' Hospital **A.**

Hockey v. Blueharts **H.**

Fri. 24th.—Soccer v. Trinity College, Oxford **A.**

Sat. 25th.—Dr. R. Bodley Scott and Mr. R. Corbett on duty.

Anaesthetist: Mr. R. W. Ballantine.

Hockey: v. Goldsmith's College **H.**

Wed. 29th.—Soccer v. Guy's Hospital (L) **A.**

Sat. 1st.—Dr. E. R. Cullinan and Mr. J. P. Horsford on duty.

Anaesthetist: Mr. C. E. Langton Hewer.

Soccer v. Queen's College, Cambs. **H.**

Hockey: v. National Physical Laboratories, Teddington **A.**

STUDENTS UNION

The Annual General Meeting of the Students Union was held on Thursday, November 28th, at 5.30 p.m. in the Clinical Lecture Theatre.

Mr. Hume was in the chair.

The minutes of the 1956 A.G.M. were read and approved.

It was announced that the following officers had been elected by the Council:

President: Mr. J. B. Hume.

Vice-Presidents: R. G. White, T. Silverstone, J. Owens.

Treasurers: Dr. G. W. Hayward, Dr. H. W. Balme, Dr. A. Macdonald.

Senior Secretary: G. R. Hobday.

Financial Secretary: F. Abercrombie.

The Senior Secretary, Mr. J. Owens, gave his report in a concise and amusing manner. He thanked the College on behalf of the male students for renovating the men's cloakroom which had cost several thousand pounds. He next congratulated the Rugby Club on reaching the finals of the Hospitals Cup and only being beaten in a replay. The Cricket Club, Women's Hockey Club and Rifle Club had also had very successful seasons. He deplored the lack of support given to the Rahere Music Society and Dramatic Society which had resulted in some financial losses. He congratulated Mr. Brian Richards on his starting of a Gilbert and Sullivan Society which had been very successful and congratulated the View Day Ball Committee on the excellent Ball held in the Park Lane Hotel. They had recommended that the 1958 Ball be held in a marquee on Charterhouse lawn. He then mentioned the rise in prices of food in the Refectory and said that Mr. Morris had agreed to put on a set meal for 2s. 3d., sacrificing quality for bulk. He then expressed the Freshmen's appreciation for the Students Union Guidebook, edited by Messrs. Bootes and Howes.

He then expressed his thanks to Dr. Cullinan, Mr. Hume, Dr. Balme and Dr. Macdonald for the help and encouragement they had given him and for the interest they had taken in Students Union affairs.

The Secretaries' report was adopted.

Mr. Sugden proposed that the View Day Ball be held again in the Park Lane Hotel in 1958. This motion was defeated heavily.

The Financial Secretary, Mr. T. Silverstone, then gave his report and said that the College had agreed to take over the running of Foxbury and to rent it to the Students Union for £450 p.a., but in spite of this saving the S.U. subscriptions would have to be raised from 6 guineas to 7 guineas per annum.

The Financial Secretary's report was adopted.

The B.M.S.A. representative then gave his report and said he unfortunately had apathy to report in regard to hospital interest in the B.M.S.A. He then pointed out that the B.M.S.A. arranged clinical courses all over Europe for those interested and had Student travel grants for those in need.

A vote of thanks was expressed to Mr. B. Hill for his work as editor of the B.M.S.A. Journal. The meeting closed at 7.30 p.m.

Council Meeting

A meeting of the Students Union Council was held in the Abernethian Committee Room at 12 noon on Wednesday, December 4th. Mr. J. B. Hume was in the chair.

Mr. C. G. Beardwell was elected Junior Secretary by the outgoing Council.

Mr. B. McGrath proposed that a Gramophone Society be formed with a view to having a gramophone and records in a suitable room in the Hospital for clinical students. A sub-committee was formed to look into this.

It was decided to post a list in the Abernethian Room to determine which were the most popular newspapers and in the interim to purchase another copy of the *Daily Mail* and *Daily Express*.

It was decided that the Union should take more part in the University of London Union's affairs and Mr. Hadley was elected as the Council's representative.

The meeting closed at 1.30 p.m.

NO FLIGHT OF FANCY

by H. A. NORTON

IT WAS a glorious Winter afternoon in 1929 ; and in that part of North Queensland we could depend on fine weather from May to October. That afternoon I had left Glen Isla, and was on my way to Manfred when another car drew level and the driver told me that I was wanted on the phone at Glen Isla—only ten miles back! It was my churchwarden—agent for QANTAS Airways then—phoning to tell me that the flying Doctor would be calling there to pick me up. We were to go to a Gulf property. I was instructed to find a paddock over which I could drive safely at 30 m.p.h. for at least a quarter of a mile each way, and to light a smoke fire in a corner of it—for recognition and for wind direction indication. Strangely enough, only two days before that, I had told my Warden that if I *had* to go in that ancient-vintage Moth plane for duty I would hardly relish it. When the plane came down—it had come from Cloncurry—the Doctor told me that I would certainly be needed, he might not be. Dr. Alan Vickers had not very long been at Cloncurry, where he was to stay for many years. That afternoon we little realised that he would for a long while live at my house, or that I would, one day, marry him to a Cloncurry girl on my return from England in 1932. Often we were to fly together, and always he was a splendid G.P., and a grand friend.

The Rev. John Flynn had had the ability to bring to reality the dream of many folk ; a dream of more safety in the outback of North Queensland, and for similar parts of Australia. Flynn was a Presbyterian, a friendly man, to whom all churches subscribed in his Flying Doctor Scheme. QANTAS (still the same name is used, though it stands for Queensland and Northern Territory Aerial Service) kept a spare plane and spare pilot ready to go almost anywhere at short notice. Alf. Trager, from Adelaide, had designed a cheap wireless transmitter-receiver for sending morse messages from isolated cattle or sheep properties.

Such sets were given first to the most isolated places, then gradually more and more were issued till most places which had no phone, and were a good distance away from Cloncurry, had their 'pedal' wireless sets. Power for transmitting was generated by pedalling—as with a cycle—and so turning a small generator. Each day, at stated hours, Alf or Harry Kinzbrunner would be listening for calls for the doctor, for messages, and for telegrams to be sent from Cloncurry Post Office. The Doctor was there too, listening for details, and giving advice concerning patients. The Doctor had beds at Cloncurry General Hospital. There were times, in the first few years, when the Flying Doctor Scheme was in desperate need of money. But far and wide in Australia, people rallied round, and kept it going. Then the Federal Government—I think that it was the Federal and not the State Government—stepped in to help financially. It has done so ever since.

Now there is a mantle of safety spread all over Australia. The Flying Doctor mentioned—Alan Vickers—is still connected with the scheme. He was over here a few years ago hoping and working for similar schemes in other parts of the Commonwealth such as Central Africa and Pakistan. The little beginning at Cloncurry has taken place in many other similar parts of Australia. When there is the chance of quick transport to hospital, over big distances such as we had, there is more likelihood that men will settle, will marry and have families in the outback places.

To the memory of the Rev. John Flynn a fine church has been built at Alice Springs. To that, as to his Flying Doctor Scheme, all denominations contributed most gladly. His work will go on.

Yet what a difference there was in means of communication between 1929 and the last time I was in the "wild and woolly West" in 1948. At first we used a plane with an engine of World War I vintage—a Siddeley-Jaguar. It stood up to the work wonderfully.

Then, Qantas planes were known fairly well in Australia, but now their routes extend nearly all over the world. The pilots who used to stand by for emergency calls have become well known—possibly the widest known being Charles Scott. He, with Campbell Black as co-pilot, won the Centenary Air Race from London to Melbourne in the first named "Comet". With well-trying aircraft, and splendid pilots; with conscientious doctors, and ability to send and to receive messages, the scheme has gone on. Small nursing homes, staffed by two fully trained nursing Sisters, who are assisted by local trainees, have been established in some places far from hospitals. Dunbar Station, for example, a cattle property of J. S. Love, in the Gulf country (Gulf of Carpentaria) is

well known, and so is the little hospital there. Both miles from anywhere.

The wireless sets, nowadays not confined to sending morse, are used not only for S.O.S. messages, but as a means of having a chat with folks scores of miles away, and also for giving day-school and Sunday-school lessons. We, in England, who have schools and churches so close, will realise what a boon this is to less fortunately placed people.

Having seen these advances made in so few years, Dr. Vickers wants other similarly situated parts of the Commonwealth to be helped in the same way.

When she was last in Australia, Her Majesty the Queen spoke over the Flying Doctor radio network, and learned at first hand something of this splendid example of team work.

PSYCHOLOGY – AN ALIBI FOR SIN?

by E. B. STRAUSS

I WONDER whether the subject which is under discussion could best be tackled by the psychiatrist, the lawyer, the philosopher, or the moral theologian, for it seems to me that it is only the old question of determinism versus free will over again, even if it is presented in somewhat modern dress. Therefore, to prevent the discussion developing on too abstract lines, may I assume that free will can never be proved philosophically, any more than can the existence of God, for instance; but that, unless it be admitted as a valid operative factor in the human situation, the whole debate would become woolly.

Our Common Law depends entirely on the axiomatic acceptance of the principle which accords a large measure of freedom of choice in matters of conduct to adult members of society not deemed to be insane or grossly mentally defective.

Is the whole applecart to be upset because certain psychologists of the unconscious come along and say that our behaviour is ineluctably determined by the emotionally signifi-

cant experiences occurring in the first four years of life? In other words, is the modern psychiatrist, especially the psychiatrist with a psycho-analytical bias, undermining society by destroying man's belief in his capacity for making moral choices? Or is he perhaps to be regarded as an angel of enlightenment bearing a new concept of justice by relieving man of an intolerable and crippling load of guilt which he has carried unnecessarily over the millenia of his organised existence. I think that both points of view have something to be said for them; nor are they necessarily mutually contradictory.

In order to clarify our ideas, it is important from the start to understand what is meant by the term "psychological determinism". Is there in point of fact so much difference between psychological determinism and other factors which, as would be universally accorded, limit the operation of free choice? Let us, therefore, now consider some of these forms of so-called determinism, if you agree to the term, starting with bodily or somatic determinants or possible determinants of behaviour-patterns. If my brain-cells become

"Opening remarks as Guest Speaker at a meeting of the '51' club in Manchester on February 26, 1957, and subsequently broadcast in the North of England Home Service of the B.B.C."

infected with the micro-organism responsible for syphilis, I may become grossly deluded, forgetful and irresponsible and commit anti-social acts arising from the resultant pathological world-picture. Clearly moral responsibility is from the forensic point of view greatly reduced.

If I harbour a certain type of gene, inevitably by the time I reach my forties or even earlier I begin to exhibit involuntary movements resembling those occurring in St. Vitus' Dance, and my mental faculties deteriorate eventually to the level of imbecility or idiocy. This is an example of genetic determinism.

If I belong to a society which believes it to be right and proper to bury aged parents alive and execute a ritual dance over the grave, my behaviour will be the result of cultural determinism.

If from an early age, I am apprenticed, as it were, to a modern Mr. Fagin, I will pick pockets with a good conscience and be mainly concerned with my professional efficiency. This would be an example of psychological determinism, my reactions having been over-influenced by the psychological environment of my formative years.

No one would dispute these various types of determinism; and there are many others. The only novel element introduced into the situation by Freud, Jung and other psychopathologists of genius is the assertion that many of these psychological determinants are unconscious. Nevertheless, it cannot be asserted categorically that moral choice is inevitably destroyed thereby.

I may, for example, have a psychologically determined fear of heights, combined with a desire to precipitate myself from on high; but whether I in fact destroy myself in that way, so long that is, as I remain merely neurotic rather than positively insane, depends on my choice. Moreover, many of the psychological explanations of conduct put forward by enthusiasts are highly speculative and debatable; nor are they necessarily explanatory in a causal sense. At their best, they establish part-causes only, in so far as they can disclose previously unconscious psychological antecedents. Good hypotheses are always spoilt by enthusiasts. Thus, if a psychiatrist were to get up in a court of law and state under oath that John Smith is not responsible for having set fire to Farmer Giles' haystack because he (John Smith) was rejected as a child by his overstrict father

who was identified unconsciously with Farmer Giles, he (the psychiatrist) would be doing his kind of psychiatry a disservice and at the same time would bring the whole of psychiatry into disrepute. What psychiatry can do — and, with increasing knowledge, will be able to do more and more efficiently — is to help to establish to what extent free choice, and hence moral responsibility, are limited by such antecedent factors. Nor must it be forgotten, as I have already indicated, that it is not only psychological antecedents which must be taken into account when assessing moral responsibility in the case of anti-social acts. Thus a man, in one of his recurrent fits of violent rage inadvertently kills his wife. These fits of rage, combined with severe headaches and epileptiform attacks, followed a severe head-injury sustained some years previously — somatic or bodily determinism. Again, a woman gasses her two children and attempts suicide by the same method, influenced by the melancholic delusion that life is so awful that it would be wrong for her to allow her children to continue to face its horrors. This was not her first attack of melancholia which had come on out of the blue, let us say. This would be a case of the operation of constitutional determinism.

It is clear, then, that if a psychiatrist can soberly and scientifically indicate the various ways in which the operation of free choice may be restricted, thereby limiting the moral responsibility, he is performing a useful service. He can help a judge or a magistrate — or, in the case of a capital offence a jury — to decide as to the best and most equitable means of disposal: should a man be sent to a mental hospital, sentenced to imprisonment, placed on probation, or disposed of in another way, both with regard to the best interests of society and of the offender himself? On the other hand, if half-baked psychological theories are so influencing the climate of modern thought as to lead men and women to think that they are the sports of fate in one form or another, psychological medicine, with which these wild theories may come to be identified in the public mind, may be deemed to be mischievous. In any case, however, any scientific discipline which helps to reveal the hidden sources of human behaviour in relation to society, leads in the long run to enlightened understanding and sympathy and discourages smugness, self-righteousness and brutal intolerance.

THE END OF THE ALEXANDRA HOSPITAL

by H. B. LEE

MOST of the London teaching hospitals have several "designated" hospitals, which function as part of their organisation. Bart's has only one, which is now threatened with closure by the decision of the Ministry of Health. Many Bart's students visit the hospital at Luton with the Surgical Professorial Unit and know something of its work, but perhaps a premature obituary notice in the *Journal* may help to obviate the need for a posthumous one.

The Alexandra was founded in Queen Square, a few doors from the Examination Hall, in 1867 for the treatment of "Hip Disease" in children. This was, of course, tuberculous arthritis, which was a common condition in those days and unless properly treated caused severe pain and illness with almost inevitable death from amyloid disease. Howard Marsh, the Alexandra's first surgeon, showed that it could in the majority of cases be cured by prolonged rest. No hospital at that time, however, could keep patients long enough, and the Alexandra was started to keep them till they were cured, no matter how long it might take. No patient was to be discharged simply to make room for another, and this principle holds good even under the changed conditions of the present time. So great was the demand for beds that soon many additional cases were treated in their homes by a sister who visited them regularly, naturally with less success than with in-patients.

Orthopaedic tuberculosis has gradually become a rarity in this country, and the work of the hospital has gradually changed. In 1920 it moved to Swanley, Kent, where it took over the old Bart's convalescent home, in the grounds of which the Bart's laundry still remains. General orthopaedics made up an increasing proportion of the work, but most of the patients were and are still "long-term". In 1940, Swanley was a risky place for children, and a very quick move was made to the present hospital, Stockwood Park, an 18th century mansion near Luton.

Poliomyelitis first became widespread in England in 1947, and another epidemic in 1948 was followed by a series of years in

which there was a fairly high incidence of the disease. Two patients who were babies when they became paralysed have been in the hospital nine years, and some severely handicapped children remain from each of the later epidemics. They need a lot of care and treatment, besides education. At the same time they need home life, and the Alexandra tries to give them the best of both worlds. A large proportion go home at weekends, and for part or all of the school holidays. This has meant that the parents have to be taught how to look after them, and in many cases they have to arrange to be away from work to do so. They find it very well worth while, and their children don't become "institutionalised" in outlook. Those who cannot have their children home regularly usually go to considerable trouble to visit them.

In recent years there has been a great interest in "spastics" stimulated largely by parents' associations in this country and the U.S.A. The picture often conjured up in the mind is of semi-idiotic children of revolting aspect, for whom nothing can be done. Like other children, however, many of them are charming and responsive. Because of its emotional associations the word "spastic" is better avoided as far as possible, and replaced by "infantile cerebral palsy" which is much more accurate and descriptive. It is usually to be traced to birth trauma with neonatal asphyxia. Brain damage is usually widespread and not confined to the motor areas where it would cause spasticity alone. It can be of any degree, and there can be gross motor damage without mental impairment. An intellect thus denied all normal associations and outlets is bound to suffer severe frustration and emotional strain.

The Alexandra has been able to help a lot of these children, as much by giving them a social life and schooling as by the various "therapies", physio-, speech and occupational. All these influences must work together if any real good is to be done. Experienced ward sisters who have the capacity for loving other people's children are essential to provide emotional stability and to train the parents and junior ward staff. Similar considerations apply to the children

of lower mental abilities. A mixture of various grades of intellect, provided that the number of the lower ones is not more than one or two to a ward, seems to work out very well, and the brighter ones stimulate the duller without themselves being kept back.

The patients are selected from a large number who apply for admission usually through County Medical Officers of Health. We try to take those whom we feel can most be benefited. This, to a large extent, rules out the really low grades of intelligence. Quite often, however, there is real doubt as to what a child's mind is like, and we admit a few for assessment. If a child cannot indicate its thoughts except by a nod or a grunt, it is tempting to imagine that it has no thoughts worth the name and relegate it to a mental hospital.

We try to observe these doubtful cases for a month or two until we feel pretty sure of our ground and have worked out the best ways of looking after them. Then we can give a reasonably firm prognosis which may be a great help to the other members of the family by enabling them to make the proper emotional and social adjustments. Parents are only human, and won't always accept a diagnosis of mental deficiency based on a two-minute interview. Often they are right and the doctors wrong. Usually they know the truth, and will admit it to themselves if enough time can be spent in explanation and discussion. Having achieved mental peace they are much less likely to spend themselves, their money and the State's, in fruitless wandering from one clinic to another in search of consolation.

None of this work can be spectacularly successful. Some physical improvement can usually be achieved, but it is bound to be gradual, needing great patience from everybody. It would be a miserably inhumane National Health Service that would deny these children the best that can be done for them. Their total numbers are not large, but

their problems are very distressing both to themselves and their families, and they are troubling the public conscience to an increasing extent. Non-medical people have to bear too much of the burden at present, and it is right that the teaching hospitals should do their share of the work so that progress can be on a sound medical basis.

Salvage work is often the best we can do at present. We make no pretence to be a machine that turns damaged children into able-bodied workers. In terms of cash results our work may seem economically unsound; this seems to be the official view and is a short-sighted one. The humanitarian traditions of eight centuries at Bart's have always rejected such thinking, and the same has been true for 90 years at the Alexandra. We cannot accept the logic of the totalitarians, which leads to the gas-chamber, even when the authoritarians are disguised as harmless bureaucrats.

The Alexandra is to be closed as a measure of economy by the 1st April, 1958, though the Governors of Bart's have done their best to prevent such a disaster and have offered to pay for necessary structural work out of "free" moneys, so that no expense would fall on the State. Somebody will have to look after each patient. If it is to be the parents, they may not be able to go to work. If it is to be another hospital there will be no saving. If their treatment is interrupted more patients will need permanent institutional care in later life, and fewer will become independent and useful citizens. If their disabilities can be minimized now they will need less trained people later on to look after and give them the basic attention compatible with contemporary ideas of humanity.

The economy may be much less than is thought, and may turn into the extravagance of years to come. This is of little importance. What really matters is the degradation of an attempt to keep up our standards of civilisation.

OBITER DICTA

Dr. N.....E O.....D. "Getting on in medicine is like walking a tightrope; where you fall off you stick."

ST. JOHN'S GATE

by B. M. J. McGRATH

HAVING entitled this paper "St. John's Gate" I feel some diffidence at taking you on a winding thread through a thousand years, often dealing with Mediterranean events rather than English. However this wide net is essential for a chronological correlation of the available data. St. John's Gate is found at the end of St. John's Lane, off the Clerkenwell Road; it looks out on a small cobbled square. Huddled amongst meat warehouses and the like, it is easily missed. When come upon by the uninitiated, it is accepted as one of the gates of the City of London. On the contrary, far from being connected with the Wall of London, this structure originally made up the Gatehouse of a Priory. The buildings and lands lay to the west of what is now Smithfield Market.

This Priory was founded some years before the erection in 1123 of the Priory and Hospital of St. Bartholomew, and was called the Priory of St. John, of Jerusalem. It was run by the Order of Knights Hospitallers; it was singled out by Wat Tyler during the Peasants' Revolt of 1381, for destruction. The closely neighbouring Priory of St. Bartholomew and the Carthusian Monastery were left unharmed at this time. It has associations with the Knights of Rhodes, the Knights of Malta, the Knights of the White Cross, and the Knights of the Holy Sepulchre.

It is towards an understanding of these associations that much of this paper is directed.

In the year 600, Pope Gregory the Great instigated the establishment in Jerusalem of a Hospice for Pilgrims; this existed for the following two hundred years. In the year 800, the ruler of the territory, Harun-el-Rashid, allowed Charlemagne to finance the re-building of this centre for pilgrims; sixty-seven years later a monk from Brittany, Bernard the Wise, visiting Jerusalem, described the Hospice: "... in which are received all the pilgrims who speak the Roman tongue ... has a church in honour of St. Mary; 12 houses; fields; vineyards; a garden; a market in front of the house, yielding market dues ...". In the year 1010

this Hospice was destroyed by the reigning Caliph but 13 years later, the pilgrim traffic having regained momentum, the merchants of Amalfi (a seaport in Southern Italy, at this time very prosperous) financed the building of a new House, served initially by Benedictine monks.

In 1069 there came into existence in Jerusalem a group of monks designated "the Poor Brethren of the Hospital of St. John, of Jerusalem", dedicated to sheltering pilgrims and ministering to the sick amongst them. Over the next 30 years these brethren worked on, kindling the admiration of many of the cosmopolitan pilgrims. In 1099 the First Crusade, under Godfrey de Bouillon, captured Jerusalem. Initially, the Poor Brethren were imprisoned; later, however, they were released to look after the wounded Crusaders. At this time a Brother Gerard was the leader of the Poor Brethren. With the enthronement of Godfrey de Bouillon as King of Jerusalem, this Crusader endowed the Brethren with considerable lands, thereby establishing them as a rich House. The Brethren, utilising the favourable atmosphere in many European States, rapidly established daughter houses dedicated to ministering to the sick, describing themselves as the Order of St. John, of Jerusalem.

Before following the advent of the Order to England, the genesis of its Rule will be traced as it evolved during the first 20 years of the Crusader Kingdom of Jerusalem. About 1112, Pope Paschall II took the Order under his protection; at about this time the Order was given exemption from tithes and all episcopal jurisdiction. It thus became a complete autonomy. Six years later a Crusader, Raymond du Puy, became its leader. During his term of office, he extended the aims of the Order to cover the defence of the sick as well as their hospitalization; this concept allowed the step to be taken of committing the Order to the protection in general of the Crusader Kingdoms. A year later the purely military order of the Templars came into existence, dedicated (albeit under solemn vows of chastity, poverty and obedience) to defend pilgrims

to the Holy Places from the ever-threatening attacks of the Saracens. With this model before him, and the responsibility of holding the numerous properties bestowed on the Order by crusading princes and nobles, Raymond du Puy moulded the Order anew. He divided its members into three grades :

(1) The Knights, who formed a fighting force for the defence of the Latin Kingdom of Jerusalem and the Holy Sepulchre against the Saracens ;

(2) The Chaplains, who were to carry on the spiritual traditions of the Order ; and

(3) The Serving Brethren, whose work lay in the manual tasks of the community.

All members of the Order wore a black robe and cowl, having a white cross of eight points upon the left breast. The ruling power was vested in the Grand Master, President of the Council. Certain knights of the fraternity were appointed by the Council to administer the affairs of the Order in those European countries in which it had possessions.

One can now follow the coming of the Order to England. Some months after the capture of Jerusalem, there returned to England a Crusader with a philanthropic bent, called Jordan Briset. Together with his wife Muriel, he gave a tract of his land near London to the Poor Brethren of the Hospital of St. John (or rather to the Order of St. John, of Jerusalem, the name the Brethren had recently taken), so that they might set about building an English house ; this land was situated about half a mile nor' nor' west of the "New Gate" of the City of London Wall. This point and the following topographical data can be gleaned from some maps in Chauvois' "William Harvey", a copy of which is in the College Library. From the North side of the New Gate the Wall passed to a tower situated in what is now the G.P.O. van-yard, under the south windows of Outpatients'. From this tower the Wall ran East. Up to the Norman conquest the country to the north-west of the City had remained waste, being largely marsh ; this was true even up to the Wall itself at this region. It was not safe for small houses to be alone in such wilds. But with the settling in of the new authoritarian regime, projects could materialise. It would seem reasonable to suppose that the dawn of the second millenium of Christ stimulated concepts of re-awakening the fervour of the early Christians. It came about that there

began construction at sites scattered over this barren waste-land, of houses for a number of communal religious bodies, dedicated to good works. Our own St. Bartholomew's was founded in 1123, on the initiative of Rahere. The Priory of St. John's was finally completed in 1144. It was dedicated in 1185, when Heraclitus, Patriarch of Jerusalem, visited England. There seems to be no specific information on the working of the Hospital attached to the London Priory of St. John; being the mother house in these islands it failed to analyse itself. Probably a routine was followed that was at least a skeleton of that current in 1575 at the Order's Hospital in Malta. The total period of the active existence of the Priory was from 1144 to 1540. So for 400 years there were Knights Hospitallers in London, waxing and waning in the impact they made politically, but constant to a substantial outline of the original Rule of their Order.

In the course of the 14th century the Black Plague was decimating the European nations. In 1349, during an exacerbation of fatalities, the routine parochial churchyards became excessively crowded. Desiring to dedicate an adequate extra site for these plague burials, Bishop Ralph of Stratford, acquired from St. John's Priory a plot of three acres, situated at the north boundary of their lands, just south of those belonging to the Abbot of Westminster. This plot was given to Carthusian monks, who built a chapel and monastery, and dedicated themselves to pray for the plague dead buried in the pits nearby. For the next 200 years this Carthusian Monastery quietly existed near its bustling neighbour, the Priory of St. John. A manuscript dated 1430 details the help given the Carthusians by the Hospitallers in the construction of a piped water-supply from the heights of Islington village. With the expulsion of the monks by orders of Henry VIII in 1540, the buildings stood effectively idle until in 1611 an imaginative City banker, Thomas Sutton, bought them up and founded a "twin-extremes" establishment, a boys' school and an old men's alms house. This became the Charterhouse.

For a while I want to halt this chronological sequence, and survey what would have been seen by a citizen standing on the City Wall, close to the New Gate. In the early 13th century, William Fitzstephen, in his life of Thomas à Becket, writes : "... there are on the ... side of London

fields for pasture and a delightful plain of meadow-land, interspersed with flowing streams, on which stand mills, whose clack is very pleasing to the ear. There are also about London on the North-West side, excellent springs, with sweet clear and refreshing water, flowing rippling over bright stones; among these springs are Holy Well, Clerk Well and St. Clement's Well; these wells are frequented by great numbers of scholars and youths of the city in summer evenings, when they walk forth to take the air."

Surveying the region about the year 1360, one would have looked out across the ditch which bounded the thirty-foot high wall along its entire length, to an expanse of fields bare of housing, with the exception of the three monasteries which had by then been founded. In fact, apart from a cluster of cottages lying between the estates of St. John's Priory and of the Charterhouse, the land outside the Walls of the City to the North-West remained largely bare of houses until Elizabethan times.

With the increasing wealth of the Order of the Knight's Hospitallers, their leaders entered the field of those traditionally called upon by the monarchical group for the governance of England, as individuals who by virtue of their calling would have little spur towards involving themselves in dynastic squabbling. By 1381, the Prior Robert Hales held the office of Treasurer of England. Since the exacerbations of the Black Death of, especially, 1349, the extreme poverty of the mass of the peasants had lightened sufficiently, due to the extreme labour shortage, for the most enterprising amongst them to afford previously inaccessible consumer goods. This was suddenly stopped by the Poll Taxes, imposed to cover the cost of the wars that the Government were waging against France and Scotland. The efforts of Government agents to bring in the Poll Tax sparked off local risings all over England, approximately simultaneously, in 1381. A band of men in Kent elected Wat Tyler as their leader; this group, rapidly snowballing in numbers, captured Rochester Castle, and then turned towards London. Friends on London Bridge lowered the drawbridge, and Wat Tyler led a partly regimented peasant horde into London. The men of Essex, led by Jack Straw, passed through Aldgate, over which Chaucer was living at this time. The association of Robert Hales, the Prior of St. John's

of Clerkenwell, with the notoriously corrupt financier, John of Gaunt, caused the peasants to connect the Knights Hospitallers with the lawyers, whom they regarded as the artificers of the Poll Tax which had precipitated their revolt. After negotiating with the adolescent Richard II and his advisors, at Mile End, and again at Rotherhithe, the peasants divided their strength. One party repaired to the Tower of London, entered it without resistance, and seized Robert Hales, Simon Sudbury (Archbishop of Canterbury and Chancellor of England), William Appleton (the King's Confessor), and John Legg (a Sergeant). These four were taken to Tower Hill, condemned as traitors to the people, and beheaded. The second party of peasants attacked the Priory of St. John, setting it on fire. The flames were still active five or six days later, when they formed a backcurtain to the final scene of the Revolt. The peasant forces had assembled in the open space of Smithfield for a culminating negotiation with Richard II. Among the King's horsemen was the Mayor of London, William Walworth, embittered at having lost at the hands of the peasants a number of his tenements (houses of ill-repute though they were). In the course of Tyler's preamble he was struck down by Walworth. In the confused dispersal that followed, the wounded Wat Tyler was given into the hands of the monks of Bart's. But later Walworth led a group into the Priory precincts, and was able to take Tyler back into Smithfield, there to have him beheaded.

Although the English Knights Hospitallers quickly reorganised themselves, it was not until 123 years later that the Priory was finally rebuilt; the finishing point being a large Gatehouse, added by the Prior, Thomas Docwra. Also a high Bell Tower was added, to be described by Stow, in his "Survey of London, 1598", as "... a most curious piece of workmanship, graven, gilt and enamelled, to the great beautifying of the City ...". However, even by 1430 the Priory of St. John was as active as of old, for there exists the following description of a hallowed custom: "... the Knights of St. John claimed sanctuary for any who had given alms to their Order, in so far as the Priory had the privilege of burying their bodies, however they might have died ... by this device they became possessed of the bodies of felons ... which they caused to be conveyed to the Charterhouse's Pardon Grave-

yard . . . such corpses were usually fetched thither in a close cart, baled over and covered with billark, having a plain white cross' thwarting and at the fore end a St. John's Cross without, and within a bell ringing by the shaking of the cart, whereby the same might be heard when it passed, and this was called the friery-cart, which belonged to St. John's, and had the privilege of sanctuary . . .".

Rather than leave a loose end, I would like to cover the Mediterranean history of the Mother Order of St. John, especially as this history explains the association of the Priory in Clerkenwell with the various synonyms for the Order, mentioned at the beginning of this paper.

After internecine quarrelling up to 1137, the Hospitallers co-operated with the Templars, as the mainstay for fifty years of the Crusader Kingdom of Jerusalem, up to its capture by Saladin. The Crusader power then returned to Acre, which it held for the next hundred years, finally abandoning the town, to embark on the sizeable fleet possessed even at that time. In 1310 a fleet of the Order of St. John captured Rhodes. This island had a fertile soil and an adequate harbour; and it was but 25 miles from the mainland of Asia Minor, so that Christian refugees who reached the tented camp of Smyrna, or when Smyrna was lost to the Saracens, the fortified castle of Budrum, could easily be transferred to Rhodes. In 1312, Pope Clement V abolished the validity of the Templars, as no longer fulfilling any purpose. To take the fate of their former lands out of the cauldron of European monarchical intrigue, the Pope persuaded all the Powers to support the transfer of these former Templar possessions to the Knights Hospitallers, who thereby became by 1324 immensely wealthy, having large holdings in Europe and wielding a great fleet of galleys manned by hordes of Moslem slaves. Over the next 150 years the Order, by virtue of its commanding hold over the East-West Mediterranean trade route, was instrumental in staying the military and commercial penetration westwards of the Turks. In 1453, the Turks captured Constantinople. From then on, the Order slowly girded itself for the inevitable conflict. In 1470, a general summons to Rhodes was sent to all the Langues (Provence, Auvergne, France, Italy, Arragon, Germany and England). An experienced soldier, Pete d'Aubasson, having

become Grand Master, effective fortifications were constructed, so that when a Turkish army landed in 1430 on Rhodes, it was repulsed. However, 40 years later a second Turkish siege forced the Order to abandon Rhodes. Over the next seven years the fleet sailed the Mediterranean, while the Grand Master travelled Europe searching for a permanent home. He even visited England, where, ironically, the same King whose sanctuary he now sought, would in 20 years destroy the Order in England. In 1549, the Knights Hospitallers accepted the Island of Malta, as a gift from the Holy Roman Emperor of the time. In 1565, this island was successfully defended against the Turks, with the aid of many of the English Langue, who that year had been finally dispersed from England by Elizabeth 1st, after a brief revival under Queen Mary. By 1575, the Order had relaxed sufficiently to begin a general purposes hospital on the island of Malta.

Prior to the Malta episode, the details are very sparse concerning the construction or management of the hospitals of the Order. But of this hospital at Valetta, there were printed regulations, a translated copy of which exists in the Bart's library. Some extracts are of interest:—

The Personnel of the Hospital were the Grand Master; the Grand Hospitaller; the Infirmary, with care of the sick, checking on the work of the physicians, on the fulfilment of their prescriptions, and on the availability of the allotted food allowances for the patients (all kinds of different soups, soaked bread, vermicelli, herbs, boiled decoctions, milk, bread, and meat, mainly game), and special charge of the house of the foundlings, all within his charge; two Knights, amongst whose duties there lay the giving of bandages and crutches to the cripples, and the superintending of the management of the hot baths and the mercurial anointments; Armorie, charged with the care of the silver-plate used by well-to-do patients and by patients who were staff (the slaves who were patients used pewterware); Clerk of the Habit, to draw up the wills of the sick; a secular Lincier, in charge of the linen, with slaves to beat the wool of the mattresses; and the Bottigliere, in charge of all Urine, Bread, and Oil.

The training of the Brothers of the Order: Each provincial langue on one day had to wait on the patients with their food. A

watch was kept for absentees. On Holy Thursday, the Grand Master with all the Knights of the French Langue assembled, and with exemplary charity washed the feet of twelve poor men, to whom were given plentiful alms afterwards.

The medical personnel: Three chief physicians and two assistants; three chief surgeons and two assistants; six young men as assistants; a barber-surgeon (phlebotomist), in charge of leeches, cataplasms, and vassicants; an experienced elderly woman, retained to attend to cases of scurvy.

The Wards: (1) Knights and persons of the Habit, with two side rooms for wounded. (2) Middle-class laity, religious Orders, and pilgrims. (3) Large, for feverish and slight ailments. (4) Small, for severe cases and the dying. (5) Haemorrhages and Lithotomies. (6) Wounded. (7) Very large, for Galley-slaves. (8) Room, for mad people. (9) Mercurial anointings. (10) Those who take hot baths.

Consumption beds to be burnt without exception. Every ward has its chapel fitted up for saying of Mass. Also there is the chapel of the most Holy Sacrament, the door of which opens towards the ward of the dying, for the convenience of the dying.

In 1798, Napoleon Bonaparte captured Malta without any resistance from the Knights. In 1800 the British captured the island. In the Treaty of Amiens they promised to restore Malta to the Order, under pressure from their allies, who feared British naval supremacy, and were led at Amiens by the Czar, who was under the impression that the bestowal by refugees of the Order of the Grand Mastership on him, had been valid. As might have been predicted, the British kept Malta.

The end of the Order in England came in 1540, when Henry VIII rewarded the combatants of a large tournament by giving to each of the challengers and their heirs forever, in recognition of their valiant jousting in this tournament, one hundred marks yearly and a house to live in, to be maintained out of the yearly revenue pertaining to the Priory of St. John. Under his Order for Montastic Suppression, the Priory itself was closed.

In 1731, Edward Cave bought the Gatehouse, publishing there the "Gentlemen's

Magazine", and employing Dr. Johnson as a hack. In 1736, Cave started printing accounts of the proceedings of Parliament in this magazine under the cover of being "Debates in the Senate of Lilliput," contained in a bogus "Appendix to Captain Lemuel Gulliver's Account of the famous Empire of Lilliput". Around Cave there collected many brilliant and talented people, including Richard Savage and David Garrick, the latter reading over his plays to the appreciative audience in the room over the Gateway. After Cave's death, the Gatehouse passed obscure years, until in the first half of the 19th century it became a tavern called the "Jerusalem", the centre for a time of a bogus revival of the Order as a sort of stag-club. The Jerusalem was run by a man called B. Foster, who published in 1851 a highly imaginative version of the Gatehouse's history. In 1874 the Victorian "Order of St. John" bought the Gate, making it the headquarters of their First Aid and Ambulance Movement.

The quibbles about the connection, dubious and devious at best, between this last movement and the historical Order, can best be ignored, as irrelevant to the very real work that the movement has done during the 80 odd years of its existence. After the British capture of Malta, a remnant of the Knights went eventually to Rome, where the theoretical headquarters still are.

In conclusion I would stress that St. John's Gate well merits a visit. Near to the present Gate there existed the Priory Church. This was, I believe almost unique in having a rectangular chancel and a circular nave, in imitation of the Church of the Holy Sepulchre at Jerusalem. The position of the round nave of this church is marked in the cobbles of St. John's Square; its crypt, re-discovered in 1896, under the now bombed church, contains a 16th century alabaster effigy, brought from the old cathedral of Valladolid, of a Knight of the Order of St. John, recumbent, with the eight-pointed cross on his breastplate, and a boy asleep against his legs. Within the Gate there is housed an intriguing library, containing for example an illuminated Missal made for the altar at Rhodes, in 1504, and also a museum, with a comprehensive collection of the coins of the Crusader kingdoms. Should anyone want to visit the Gate, an appointment should first be made with the custodian.

NIGGERS IN THE WOODPILE

by DR. GEOFFREY BOURNE

THIS colourful transatlantic phrase strikes the imagination by the apparent inconsequence of its content. What the nigger was doing in the woodpile no one has ever found out, but his sudden discovery there is taken to illustrate the introduction into some situation of a completely unforeseen complication. In these days of racial readjustment a companion picture may perhaps be offered of a white man in a snowdrift. Either position is equally unexpected and uncomfortable.

In clinical medicine there are some situations which are dangerous, not only from their being rare and therefore unsuspected, but from the fact that lack of suspicion and the associated lack of a proper diagnosis may produce unpleasant consequences. The results may be serious for the patient, for the reputation of the practitioner, and even sometimes disastrous for the community. The first examples discussed below come from the writer's earlier days when general medicine had an equal interest with cardiology, the latter "niggers" are cardiological.

Typhoid Fever. Typhoid fever has now become rare, thanks to the activities of public health authorities and to the improvement in sewage disposal. Nevertheless occasional sporadic cases occur. They are found in patients who have arrived from overseas, but may also occur as a result of carrier infection. Such cases can easily be the start of epidemics, especially if they remain undiagnosed. Epidemics have in the past sometimes been due to deviation from social routine, for example to the distorted pride of some carrier who feels it beneath his dignity to use the bucket provided for urination or defecation at the bottom of an artesian well or by the side of a reservoir in which he is working.

At the onset a case of typhoid fever is apt to be rather insidious, but the following points should always lead to the suspicion of enteric. Headache is nearly always unusually severe, and is often associated with abdominal discomfort, also with some change in bowel habit either in the direction of constipation or of diarrhoea. Examination of the patient shows an unusually slow pulse

rate in spite of the presence of considerable fever. Furthermore, the spleen although soft can frequently be felt. At this stage a white blood count invariably shows a leucopenia. In the first week the Widal reaction is negative, but the blood culture, particularly in a bile medium, is on the contrary usually positive.

Smallpox. A second rare but dangerous disease which may insinuate itself unsuspected into practice is smallpox. One afternoon some years ago I came to the Hospital to do my afternoon round and was met by the house physician in the Square. I asked him whether there was any good teaching case in the wards and he replied "No, there is only a patient with rather severe influenza." In view of the paucity of material I spent some considerable time over this case. He was a man of 24 who had been perfectly well until a few days previously when he became febrile and began to suffer from fairly severe pain in the lumbar region. I discussed the possible causes of lower lumbar pain, both acute and chronic, and proceeded to examine the patient. A definite but not very profuse eruption was present over the forehead. It looked rather like a scattered type of acne. I remarked to the patient that he had probably had these spots for quite a long time. "No", he replied, "they came out two days ago". Rapid calculation elicited the fact that there was an interval of exactly three days between the first symptoms and the appearance of these spots. He was then stripped naked and examined carefully. A few more spots were found, all of them on the fingers or on the feet. The Medical Officer of Health of London was summoned by telephone and on his arrival he confirmed that the patient had attenuated smallpox; thanks to vaccination in infancy he made a good recovery. A case of smallpox in Bart's made some little stir; failure to diagnose it would have had unforeseen consequences.

The diagnosis was suggested by the pain in the back, the exact relationship between the onset of symptoms and the onset of the rash, and by the fact that the eruption was clearly centripetal rather than centrifugal.

Amoebiasis. A third example of an insidious condition rare in this country, but important because of its good response to treatment, is amoebiasis. This usually shows itself in England in the form of hepatitis, and there has quite often been a long interval between the original attack of amoebic dysentery and the inflammation of the liver. Such an interval may extend over a period of years. The disease starts with comparative suddenness, the outstanding symptoms and signs being fever, sometimes with profuse sweating, liver discomfort and pain, and sometimes a right-sided pleurisy. The type of pain over the liver is characteristic.

I was asked to see a young man who was thought to be suffering from influenza with secondary pleurisy, but his symptoms had failed to respond to antibiotics. It was during the course of an epidemic of influenza, and the fever, sweating and general discomfort were indistinguishable from those of the influenza patients. He had a right-sided pleurisy with a friction rub, but in addition he complained of pain in the upper abdomen radiating to the right flank, which was obviously elicited by liver movement. When he turned to the right or to the left this pain, arising from local peritoneal inflammation, was induced by the consequent displacement of the heavy organ to either side. At this stage he was asked whether he had ever been in the East and he answered in the affirmative. He also admitted to having had dysentery there some seven or eight years previously. Amoebic cysts were found in the motions and his symptoms quickly subsided with emetine treatment.

Gout. Chronic and latent gout provides another of these "negroid" diseases. Perusal of 18th and 19th century memoirs show a high incidence of acute and chronic gout among prominent individuals. Accurate description proves beyond a doubt that the diagnosis was correct. Moreover gout is an inborn error of metabolism which is not infrequently familial, and which could hardly die out of the population. This conjunction of facts makes one wonder why obvious clinical gout has become so rare. There is some evidence to suggest that in fact gout is still present in many people, but for some reason — nutritional or environmental — it has ceased to light up into an acute clinical picture. Chronic gout may be suspected in the following type of case: an individual whose youth makes unlikely a diagnosis of

what, in an older person, would be that of fibrositis; or an older patient complaining of arthritis which affects at different times different joints, and whose signs and symptoms are clearly not those of rheumatoid arthritis, osteo-arthritis, or infective arthritis. In each case the symptoms clear up completely and only return at intervals. A raised blood uric acid is found and treatment as for gout clears up the situation completely.

Thyrotoxicosis. The first of the cardio-logical "niggers" is toxic goitre. This may show itself as simple congestive heart failure, often with auricular fibrillation. The age of the patient is usually between 50 and 60. As a result of a full history-taking and a complete physical examination no aetiology which could be responsible for the heart failure is discovered. The patient has never had rheumatic fever, there has at no time been hypertension, and all positive evidence of coronary disease in the shape of anginal pain or electrocardiographic changes is absent. The characteristic here is the inability to account for the heart failure.

A second way in which toxic goitre may reveal itself is by the presence of auricular fibrillation, here again without any evidence of a causative aetiology, but in this case without heart failure. Furthermore the auricular fibrillation fails to respond to adequate digitalis therapy even although the patient is carefully nursed in bed. Digitalis in such cases can be pressed to full doses but the ventricular rate remains at about 100 to 120.

A third indication of the presence of toxic goitre is paroxysmal attacks of tachycardia. These may be in the shape of classical auricular paroxysmal tachycardia, or of paroxysms of auricular fibrillation, or finally of attacks of auricular flutter. Once more no adequate aetiological cause can be found in the patient.

In these three clinical situations the points to look for in the patient are as follows. The history may elicit loss of weight which has usually occurred recently, say within the last six months. Furthermore the patient may have been conscious of feeling unduly warm. Sweating may have become prominent, or nervousness and nervous tension may have been noticed. On examination the patient may have a slightly staring look but great care must be taken to find out whether this is a personal peculiarity, having always been present, or whether friends and relations have recently remarked upon it. Inspection in such

cases may reveal no exophthalmos as such, but one eye is clearly a little more prominent than the other, a fraction more of the sclerotic showing above the iris on that side. On palpation the skin of the patient is uniformly warm to the touch and rather suggests that he or she may have recently come out of a warm bath. The surface may also be slightly moist, but there is no markedly local sweating. Tremulousness may be present, tachycardia is usually found and the pulse pressure is quite often increased. Careful examination of the thyroid may or may not reveal a definite swelling. This, though slight, may be diffuse, or it may be restricted to a single adenomatous lump buried deep in the neck. As the patient swallows it may become visible, or it may be detectable by careful palpation. The diagnosis is confirmed by basal metabolic estimation, or by measurement of the radioactive iodine uptake.

Subacute Bacterial Endocarditis. Subacute bacterial endocarditis is by no means always diagnosed during its earlier stages. The following points are suggestive of it. A patient with a heart murmur may have started to sweat at night, and if the temperature has been taken fever has been found. Pains ascribed vaguely to rheumatism are often present at this stage of the disease, the important point being that they have only been of comparatively recent onset, never having been noticed before; and that the patient is young to be a martyr of what is usually regarded as a prerogative of the elderly.

It is curious that the murmurs which are heard are usually murmurs of regurgitation, either mitral or aortic, rather than those of stenosis of these valves. This is an inexplicable but definite clinical truth.

Syphilitic Aortitis. Syphilitic aortitis is another condition in which the aetiology is not always suspected. There is usually the murmur of aortic regurgitation. A careful history often reveals that the patient has been examined in earlier years for the Services, for life insurance, or for some civilian activity, and that the heart was then found to be normal. In other words, the aortic diastolic murmur appears for the first time after the age of 35, usually later. The diastolic aortic murmur is nearly always louder on the right

side of the sternum than on the left. In early stages the heart is little enlarged and the diastolic pressure has not appreciably fallen. The patient remains singularly free from symptoms, even after the aortic leak has become considerable.

Coarctation of the Aorta. Coarctation of the aorta is a further cardiological abnormality which is less rare than is often supposed. All young individuals whether children, adolescents, or young adults, in whom the blood pressure is thought to be higher than normal, should be carefully examined for this condition. The aorta must be palpated in the abdomen, and the femoral vessels in the groins. If pulsation is absent or obviously diminished the blood pressure should then be taken in the legs as well as in the arms. Contrary to the usual procedure a more accurate correlation is obtained between these two sets of figures by taking the blood pressure in the radial artery by palpation, rather than by auscultation, and comparing it with the blood pressure in the dorsalis pedis or the posterior tibial vessel, estimated also by palpation. The interscapular area should then be inspected for the presence of visible arteries, the patient standing in an oblique light with the head drooped and the arms also hanging loosely forwards. Radiological investigation will usually show the diagnostic subcostal symmetrical grooves, especially beneath the lower ribs. Surgery is generally curative.

Dissecting Aneurysm. Dissecting aneurysm is a further example of a condition considerably more common than is generally supposed. It often masquerades as myocardial infarction. The onset of symptoms is nearly always rapid. Pain is the outstanding one. It is felt in most cases rather lower in the chest than is that of myocardial infarction. Furthermore the pain may be more to one side than the other. Shock is frequently severe. If the carotid vessels are involved mental confusion or hemiplegia may supervene. Arterial pulsation may be unequal as between the arms or the legs, as revealed by the sphygmomanometer. Aortic incompetence, recent in origin, or blood-stained pleural effusion may complicate the picture. The electrocardiogram in most cases remains normal.

MEDICINE AND THE ARMY

by LIEUT. GENERAL SIR ALEXANDER DRUMMOND, K.B.E., C.B., Q.H.S., F.R.C.S., D.L.O.,

Director-General Army Medical Services

The Abernethian Society was founded in 1795 at a time very similar to the present. Britain was in a state of what we describe today as cold warfare. Frigate battles were taking place around the coast of France, Lieut.-Col. John Moore, the future hero of Corunna was in Corsica and the Dutch were being relieved of the Island of Ceylon. Since that time many of our distinguished medical officers have been recruited from your ranks. In times of emergency you have never failed to hasten to our aid.

Within living memory the most distinguished of your company who came to our assistance was Major-General Sir Antony Bowlby. He and Lady Bowlby were both with us in the Boer War. I would remind you that in the 1914-18 or Great War, it was due to Sir Antony's researches, industry and self-sacrifice that so much was done to reduce the morbidity and the mortality of the wounded. I would repeat self-sacrifice — Sir Antony unlike so many of his eminent contemporaries gave up much of the practical and the more rewarding side of surgery in order to obtain the "know how" in what we term today the forward defended localities. Here, he analysed the results of individuals and ably grouped suitable and kindred surgeons into operating teams. What is more he inspired them to consider themselves as integral members of a master plan which provided the surgical cover for our armies in France. It was largely due to his intuition that surgeons and medical units were pressed forward to deal with the wounded at the earliest possible moment. Further, he taught the front-line surgeon to realise that his task was to undertake the primary stage of the definitive work which would be completed at the base. It will interest you to know that Sir Antony's method of surgical cover has today become the routine practice of all enlightened armies. It was from notes such as these written in small pocket books that he was able to devise and plan the means of efficient treatment of mass casualties. These are the actual diaries which were given to the safe custody of the

officers of the Royal Army Medical Corps by that very charming person — Lady Bowlby — shortly before she died.

On Sir Antony's experience, investigations and his accumulated statistics it became possible to forecast with sufficient accuracy the expected number of seriously and dangerously wounded that would occur in any big attack and his simple rule of 2 per cent enabled the staff to make all arrangements to meet the needs of the wounded. He found that in every 100 cases certain wounds might be expected to occur at a rate of two per cent. These were wounds of — the skull, the thorax, the abdomen, the femur, the knee joint, the leg, the humerus, the fore-arm and the elbow totalling 18 per cent in all. If today we add six per cent for burn cases we obtain the approximate figure of dangerously ill patients in modern warfare. As the result of his organisation in the surgical field Antony Bowlby became an important instrument in reducing man-power wastage. Through his charm and friendliness he became the confidant of the great captains and his opinions on diverse subjects were sought. In consequence he did much to raise the standards and status of the Medical Services of the Army.

In the Army today the relationship between the Medical Services and the Command is very close. This has not always been the case. As would be expected, the degree of relationship has always been in direct proportion to the usefulness and efficiency of the medical officer. In the Middle Ages Commanders were normally accompanied to war by their private physicians and barbers. With the formation of the standing Army in 1660, surgeons and physicians purchased or were given their commissions and were appointed to regiments. Here, they concerned themselves not only with doctoring the troops but also with the care of the regimental families. Even in these early days the value of contented and stable married families was well recognised. At the time of the Crimea Campaign the overall control of the Army Medical Establishment was

centred in a medical board comprising an Inspector General of Hospitals, a Surgeon General and a Physician General. The drugs, medical equipment, supplies and stores, were not under the charge of this Board but of an Officer designated the Apothecary General. The supply and issue of what today we call accommodation stores, as the bed in which the patient lay, the blankets which covered him and also the supply of rations, were the concern of yet another individual called the Purveyor whose department was directly responsible to the Secretary of State for War. It was, therefore, small wonder that medical officers were considered of secondary importance. To senior military officials it seemed that medical officers although skilled in curative medicine, therapeutics and morbid anatomy were fit for nothing but to take care of those suffering from the effects of war or foreign climates, in fact, before this campaign, doctors—civilian or military—had contributed little or nothing to the prevention of manpower wastage.

At the time of the Crimean War Louis Pasteur was postulating the spread of diseases by germs, but, as yet the medical officers lacked the applied knowledge that bacteriology and immunology were later to afford them. The necessity for well qualified medical officers was realised and in 1898, a new corps, The Royal Army Medical Corps, was formed, the members of which were, incidentally, given the same ranks and insignia, the same status, and the same executive and disciplinary powers as their combatant colleagues. This was a most important advance as these privileges, I believe, have not yet been fully accorded to the medical officers in the sister services of the Defence Forces of Great Britain.

Anti-typhoid and other inoculations were now protecting the armies in India; at the same time, advances were being made in tropical medicine and epidemiology. For example, Bruce who originally discovered the organism of brucellosis, had traced its reservoir to goats. Leishman had revealed the causal protozoan of leishmaniasis. LeLean was working on the downward displacement of steam as an effective sterilising agent. It may be safely said that at the outbreak of the Great War in 1914 the Army Medical officer had the training and knowledge, and I would add, the efficiency to warrant his place in the councils of war. Enteric was no longer a fatal disease. Hygiene and sanitation were

curtailing typhus, while malaria and dysentery were being checked. Tetanus and gas gangrene presented as lethal diseases to be eventually controlled.

Nervous disorders and psychoneuroses took pride of place as manpower wasters of the Great War. The immediate remedy was therapeutic which gained the Medical Services of the Army a few marks and cost the nation a considerable amount of money in pensions. It was not however until the advent of the World War of 1939 that personnel selection was introduced as a means of preventing this form of manpower wastage.

Protection against Gas was one of the problems of the Great War that the medical services were asked to solve. The expedient instructions issued that those liable to be affected should climb up the nearest tree although theoretically sound was not practicable. The Royal Army Medical College with the help of the Royal Engineers provided the solution.

The devastating epidemics of measles and cerebro-spinal fever were other problems which were dealt with largely by the Medical Officers' ability to administer and organise.

The successful treatment of the masses of casualties in France and other theatres brought credit to the Medical Services. The Royal Army Medical Corps had achieved a position of responsibility as savers of manpower.

In the inter-war period stress was again laid on improving the professional standards of the Medical Services. In addition, the importance of training for war was taken up with greater emphasis than ever before. It was realised that it would be upon the scaffolding formed by the regular Medical Corps that the Army Medical Service would have to expand. What of the 1939-45 War. How did the medical officer stand with his commander? What has Field Marshal Viscount Montgomery of Alamein to say when making a presentation to the Medical Services?

"To the Royal Army Medical Corps with admiration and high regard, and with gratitude to a Corps whose contribution to history has been beyond all calculation". In a despatch he wrote of the

"... truly remarkable success of medical organisation. . . . Doctors are prepared to lay fifteen to one that once a man gets into their hands whatever his injury, they

would save his life and restore him to fitness".

As you would expect the duties of a medical officer in the British Army are varied. Automatically at all levels, no matter what his specialty he is an adviser to his commander. The more senior the commanders in the British Army the more medically minded they become. To give confidence, therefore, the medical officer must be up to date in his professional knowledge and be rational in all his arguments. Except in operational necessity his advice is readily accepted. Should operational necessity arise a working compromise is always effected.

In planning a campaign, medical at all stages is called in. Advice is given in the form of a written appreciation which assists the staff and its commander in making their plans and decisions. The medical adviser is today a valued member of the staff. His advice, as was the case in the South West of the campaign. This position of confidence Pacific in the last war, influences the whole has been gained as a result of concerted medical efforts chiefly in maintaining the health and saving manpower wastage of the Army over many years.

Medical officers by the efficient handling of their medical resources can demonstrate to the soldier that he will be quickly and adequately treated if wounded. This knowledge plays an important part in maintaining what Field Marshal Montgomery has referred to as the most important single factor in winning the battle, namely, morale.

It is for the future that the medical officers of today must train. A sound professional knowledge is the essential background. In his academic qualification, training and experience he must at least equal his civilian colleague. What is important is that in the Army of today he is given ample opportunity to achieve this.

You no doubt will have realised that after each major war, it has become almost traditional for the Government to reshape its Army Medical Services. The recommendations invariably include schemes for improving conditions of service and enhancing the professional or clinical standing of the members. The last Committee — The Waverley Committee — in 1956, among other things, recommended that our sister services should bring the professional standards required by their specialists into conformity with those laid down by the

Army. This recognition of our professional standards was very gratifying, not only to members of the Medical Services of the Army, but also to our civilian colleagues who ever since the formation of the regular Army have gone out of their way to encourage and help us in raising these standards.

What are our present standards? It is necessary that senior specialists in the Medical Services hold the higher academic qualification of their specialties and have the requisite training and the experience recommended by the Royal Colleges and the Joint Consultants' Committee of the British Medical Association. In order to attain these standards a career guidance scheme was laid down as far back as 1947.

Today 40 per cent of our regular officers are specialising. Before grading as a specialist the candidate is interviewed by a board consisting mainly of leading civilian consultants, who assess his qualifications and experience and if they equate with those of a civilian consultant, recommend that the candidate should be graded and appointed as a specialist in the Army. The board then recommends that he be posted to a particular unit for a tour of duty. This system is identical with civilian procedure.

At present approximately 40 per cent of our regular officers hold postgraduate or higher medical qualifications — a greater proportion than, I believe, is found in civilian life.

Although the career guidance scheme is normally confined to regular and short service officers I am happy to say that a large number of our National Service officers also benefit.

Before being permitted to train as specialists, officers are required to pass satisfactorily the Junior Course of the Royal Army Medical College.

If selected the candidate at an appropriate time is sent on a three months' surgical basic science course, or a membership course for the examination of the Royal College of Physicians. If successful the surgical aspirant studies for the final Fellowship examination while the new Member of the Royal College of Physicians works for his doctorate.

What happens if a candidate is not successful on the junior course?

On one occasion I was rung up and informed that such an officer had been

successful in his Membership examination. Originally it was his intention and still is, to specialise in psychiatry. He was told to show his capabilities by passing his membership examination, after which we would train him and make him into a psychiatrist. About this same time another officer wished to become a pathologist but did not gain sufficient marks. Similarly he was told to obtain his Membership. Unfortunately the Suez operations interrupted his academic progress. As M.O. to the Scots Guards there was little time to get down to the books. It will not surprise me if after the next examination he reports that he has obtained his membership. If so he will start his training as a pathologist the next day.

All postgraduate training is now co-ordinated by the Director of Studies, who is Commandant of the Royal Army Medical College. Today it is thought necessary that all officers, specialist and non-specialist, returning from an overseas tour should undergo a refresher course in their particular subject.

Our career guidance scheme is theoretically simple and few difficulties are encountered with the unmarried officer. When a difficulty arises it usually concerns the married officer's family which very rightly must be considered. The career guidance staff appreciate that one of the first principles in running a contented service is to maintain a happy community which involves focussing particular attention on the family. To this end in selecting officers for regular commissions special attention is now paid to their family background.

The Suez operation was an important Medical Exercise. Surgically a lot had to be re-learned. It has certainly given us timely guidance for the future. During the planning stage it was decided that casualties occurring in the first phase of the landing would be ferried direct to the ships until such time as the medical units had been disembarked. On the outward voyage, aircraft carriers of the Royal Navy and military transports, carried the striking force. Consequently the public rooms of these vessels which were to be converted into wards, operating theatres and sterilising rooms could not be prepared and organised for their medical role until the disembarkation of the troops was well under way.

Instructions were given to the Cambridge Military Hospital, Aldershot to pack and sterilise all dressings, gloves, gowns, theatre linen and syringes to cover the requirements of the military units both afloat and on the beach for the first phase. In other words the Cambridge Military Hospital, which normally provides some 50 medical units of the Aldershot area with sterile syringes and supplies, on this occasion extended its sterile supply service to cover the Mediterranean operational area. It is of interest to find that among other things the forward surgeons of the Great War recommended that it was advisable to issue field units, etc., sterile dressings packed in parcels of three different sizes.

In this operation some medical officers neglected the cardinal principle of military surgery, namely, never to undertake the primary suture of a wound received in battle. Delayed primary suture for many years has been the established rule whether or not antibiotics are used. Frankly, the temptation to close a wound and allow it to heal by first intention was great. Time was on the Surgeon's side and antibiotics at his call: Had not some of the troops been flown from their transport, landed on the beach, joined in the fight, been wounded, flown back as casualties and were now lying comfortably as patients in the ship's hospital all within twenty minutes?

Helicopters were the answer, they are wonderful time savers but it had to be re-learned that speed and antibiotics are not the alternative to efficient debridement. Unfortunately it was also forgotten that the missile passing through tissues still retains its disruptive and damaging effect and its tract must be followed up. Forward surgery was the lesson of the 1914-18 or Great War, that of the second or World War, delayed primary suture. If wounds were treated as directed 90% of them could be sutured in five days. In the best interests of his patient the experienced forward surgeon appreciates that his job is to prepare the patient's wound for a delayed suture in 5 or 6 days time. If he does this adequately, massive scar tissue is eliminated, compound fractures are converted into simple ones and sinus formation prevented. In fact the forward surgeon if he carries out his allotted task, reduces manpower wastage and is the chief

means of restoring his patient to fighting fitness in the minimum of time.

You will remember that with the publication of a recent white paper the division gave way to the brigade group, a stream lined force designed to meet our modern commitments be they cold, limited or global. The object of the cold war is well known. It aims at destroying man's peace of mind and undermining his morale. This was obvious at the Congress of Military Medicine held in Belgrade last month.

In considering defence in nuclear warfare with particular reference to the effects of radiation. Delegates were being persuaded into making a collective recommendation which the Congress desired to send through ministerial channels to the governments of those participating. The purport of the recommendation was that the military surgeons present had no effective remedy at their disposal, and the position in their opinion was hopeless. The situation described by the Preacher in Ecclesiastes came to mind—

'in the day when the keepers of the house shall tremble, and the strong men shall bow themselves, and the grinders cease because they are few, and those that look out of the windows be darkened.'

This today is the mental state of those who live under the shadow of the iron curtain. Their doctors and surgeons have been so conditioned that they now fear radiation of any kind be it from their wristlet watches or the asphalt on the roads. These brain washed people are worried. They fear the unknown.

Catastrophe or major disaster is not unknown to you people of St. Bartholomew's. In 1603 no fewer than 30,000 died around this hospital. A similar number perished in 1636. The Great Plague of 1665 did not destroy such a large number. It however struck the imagination for it came at an age of greater civilisation, comfort and security when such calamities are less expected. The plague was not confined to London, the towns of East Anglia also suffered very severely. Harrison Ainsworth's words in *Old St. Paul's* are descriptive of what might occur today should there be a nuclear attack.

"London had become one vast lazar house, and seemed in a fair way of becoming a mighty sepulchre."

The chief feature of nuclear warfare is the complete and sudden nature of the casualties occurring in all depths of the theatre of operations. While factors of size, speed and multiplicity increase the complexity of the problem, progress in medicine and science equip us better to deal with it and give a solution far removed from the pest house and plague pit of old London.

Individual training, versatility and mobility of medical units tied to a flexible organisation are, we feel, the means of meeting the difficult but possible nuclear commitments.

It is now of paramount importance that every medical or patient holding unit, be it a field ambulance or a military general hospital, be trained and organised in the sorting, filtering, early management and sustaining of casualties. In the modern Army the field ambulance is trained and organised to filter some 6,000 casualties in 24 hours.

At the site of an incident the field ambulance will sort out its casualties into three groups. First the lightly wounded—patients with fractured limbs and lacerations. Fractures will be put up in gutter plasters by R.A.M.C. or Q.A.R.A.N.C. nursing orderlies. A team of twelve who have been specially trained are capable of putting up 100 cases inside one hour. These orderlies do not set the fracture but merely straighten the limb and immobilise it by means of a quick setting plaster slab.

The second group are the transportation risk cases which some people might call moribund. These patients are set aside and treated expectantly—but they must be treated or morale will suffer. The third group are the seriously injured who may require life saving procedures which can be readily undertaken if surgical teams are available. It is unlikely however that there will be sufficient surgical teams and the unit will have to sustain these casualties for anything up to eight days.

Let me now tell you what we expect our medical units to be. There will be a unit of—

- 3 medical officers.
- 3 nursing officers or SRNs
- 33 nursing orderlies
- 3 cooks
- 3 clerks

It is so organised as to divide into three sections or wards. The commitment is 100 dangerously ill patients. The brick complete with its tentage, equipment and personnel

can be carried on six 3 tonners and three trailers.

On arrival on site it can unload, erect its tentage, lay out the beds and admit its 100 dangerously ill patients within 1½ to 2 hours by which time the majority of the patients have been documented and put on support treatment, i.e., temperature, pulse, respiration and blood pressure have been recorded, they have been sedated and given their antibiotics or chemotherapy. Those that require gastric suction or a gastric drip have had a Ryle's tube passed. It is anticipated that by this time an intravenous drip has been started in 60 per cent. of patients.

A lecture given to the Abernethian Society on 19th November, 1957

Meanwhile the cooks have prepared the patients' and staffs' diets and food while other orderlies have provided the required sanitary arrangements.

This standard of proficiency has been achieved by streamlining the training and making it more interesting. It will surprise you that the personnel of these medical companies are not hand picked but contain a goodly proportion of people with SG 4 or 5 gradings, people who are not usually given responsibility and are apt to be described as dullards. In this organisation we have been able to bring the medical officer and the other rank into a much closer relationship than ever before. As you can well imagine everything depends as never before upon the leadership of the medical officers.

SPORTS NEWS

Viewpoint

Readers of the National Daily Papers may have noticed that the Bart's Rugger boat was the only Crew to win for the Hospital in the Hospitals' Regatta. Although this may seem to be yet another "feather" (if the expression be excused) in the cap of the Rugby Club, it should be pointed out that the four victorious oarsmen had I am informed served the Boat Club faithfully and skilfully for some years previously, and that their allegiance to the Rugby Club, was, with deference, of short standing. Alas for the old amateur spirit (if there ever was such a thing) which is slowly being ousted by mechanically streamlined professionalism.

The Sporting Calendar has been enlarged to include fixtures for the month following that in which the *Journal* is published. This is a logical and self-explanatory step.

1st XV v. Old Paulines at Thames Ditton. November 16th. Won 12-0.

The 1st XV scored a convincing win over Old Paulines at Thames Ditton by 12-0 and had they accepted their chances and not missed several easy shots at penalties, could easily have doubled their score.

The Hospital kicked off on a dull but dry afternoon and soon established a foothold in the Old Paulines half, staying there for most of the first half. Stevens opened the scoring with a thirty-yard penalty after twenty minutes and ten minutes later, McMaster finished off a good move by beating two men to score an unconverted try in the corner. During this phase of the game, the Hospital forwards were getting an equal share of the ball from the set-scrums and line-outs and often made 20-30 yards by well-controlled dribbles in the loose. After the interval, Bart's again re-established themselves in the Paulines' twenty-five and further scores came in a try scored by Halls after a well-placed kick-ahead by Bamford and a 35-yard penalty by Pennington.

It was, however, a pity to see so many scoring chances wasted as the Old Boys were noticeably weak in the centre. More determination and ruthlessness must be shown by the Hospital against weak opposition as it is in these matches that the skill and fire required next January must be developed.

It was pleasing to see all the junior sides win again as it is a comforting thought to know that the general standard of rugby throughout the Hospital is definitely improving.

Team:

M. Britz; J. Stevens, G. J. Halls, J. Bamford, A. B. M. McMaster; R. R. Davies, B. Richards; J. L. C. Dobson, J. Hamilton, B. Lofts; L. R. Thomas (Capt.), J. Pennington; P. D. Moynagh, W. P. Boladz, R. P. Davies.

1st XV v. Old Alleynians at Dulwich. Lost 5-11. November 23rd.

With the excellent record of having won six of the first ten matches, the 1st XV were reasonably confident of beating one of the stronger Old Boys sides in London. However, as in past years, the ground at Dulwich proved to be very greasy and towards the end of the game, became extremely muddy.

Bart's kicked off and were soon attacking up the slope and early on, Halls and Bamford engineered a clever opening for Halls to break right through. However, the vital final pass went astray and the Hospital lost an early opportunity of taking the lead. The remainder of the half was very even with Bart's getting their fair share of the ball, forward D. A. Richards making a very welcome come-back for the first time this season since his injury of last season, was often prominent in the loose mauls and line-outs. During the last quarter of an hour of this half, the Old Boys missed three easy shots at penalty goals.

After the interval, The Old Alleynian kicker, Wait, kicked a good 35-yard penalty which was followed almost immediately by a try by their right wing who won the race for the touch-down after a very well-placed diagonal kick by their fly-half. This was converted by Wait who then kicked a second penalty goal five minutes later.

At long last, the Hospital were galvanised into activity and scored a try by McMaster after he had won the race for a touch-down from a diagonal kick by R. R. Davies, J. Stevens converting with an excellent kick from the touchline. The match ended with Bart's unable to penetrate one of the tightest defences it had met this season. In the second half, the old fault of running across the field showed up again in our back division. This must quickly be eradicated and replaced by smart, quick passing to the wings as it is only by these methods that we will tire the opposing forwards and go a long way towards compiling a few big wins before the Cup matches in January.

Team:

J. Stevens; J. C. D. Plant, J. Bamford, G. J. Halls, A. B. M. McMaster; R. R. Davies, B. Richards; D. A. Richards, J. W. Hamilton, B. Lofts, L. R. Thomas (Capt.), J. Pennington; J. C. Mackenzie, R. Jones, R. P. Davies.

1st XV v. Saracens. At Chislehurst on December 14th. Won 3-0.

The 1st XV gained a well deserved victory at Chislehurst by beating a strong Saracens side by

a try to nil. It was all the more commendable since Phillips, L. R. Thomas, Halls, Britz, Bamford and Dobson were absent through injuries and notable deputies were Neely, Ross and J. Martin.

With Mackenzie leading the side for the first time since his victorious season of last year, the tactics were well planned beforehand in that the ball was kept forward as much as possible and resolute tackling by Stevens and Neely in particular completely upset the opposing three-quarter line.

Winning the toss, Bart's elected to play against a strong wind and battle was soon joined between two vigorous and occasionally over-enthusiastic packs. It was noticeable at this stage, as throughout the game, how Mackenzie held the Saracens fly-half in submission and Charlton's sudden sharp breaks round the scrum were often productive in gaining twenty or thirty yards. After Saracens had missed two fairly easy shots at penalties, Bart's took the lead with an excellent try in the right-hand corner. Heeling the ball from a loose maul fifteen yards from the opposition line, R. R. Davies created an opening and with a one man overlap on his right, passed out immediately. Quick passing by the centres enabled J. Martin, playing his first game for the 1st XV, to dive over in the corner, Stevens narrowly missing the conversion.

After the interval, although the forwards were often beaten in the set scrummage, they were much quicker on to the loose ball than their opposing numbers and possession was often more of a hindrance to Saracens due to the excellent tackling of Martin, Stevens and Neely. Ross, also playing his first game for the 1st XV in the full-back position, time and again fielded the ball and found a good touch with great confidence. During the last ten minutes, twice he saved almost certain tries with fearless tackles. Beyond this, Saracens rarely looked like penetrating Cup-match standard defence although they did miss two penalties before the close.

This, indeed, was a most heartening performance as a month previous, Saracens had beaten St. Mary's 19-0 and drawn with the London Hospital 6-6. With such a boost to morale, it is to be hoped that everyone will train all the harder for the Cup match against St. Thomas's in a month's time.

Team:

A. P. Ross; J. Martin, J. C. Neely, J. Stevens, A. B. M. McMaster; R. R. Davies, C. A. C. Charlton; D. A. Richards, J. W. Hamilton, B. Lofts, J. Pennington, C. H. Dale, R. P. Davies, W. P. Boladz, J. C. Mackenzie (Capt.).

BOOKS RECEIVED

Inclusion in this column does not preclude review at a later date.

I Walk on Wheels by Elizabeth Shepard-Jones. Geoffrey Bles. Pp. 187. Price 15/-.

Chronic Bronchitis, Emphysema and Cor Pulmonale by C. H. Stuart-Harris and T. Hanley.

John Wright & Sons. pp. 252. Price 42/-.

How to Study by Morgan & Deese. McGraw Hill. Price 11/6.

Handbook of Neurological Examination by Denny-Brown. Oxford University Press. Price 22/-.

BOOK REVIEWS

HANDBOOK OF HISTOPATHOLOGICAL TECHNIQUE (including Museum Technique)
by C. F. A. Culling, F.I.M.L.T. Butterworth.
Pp. 446 and 79 figures 45s

This book has been written primarily for laboratory technologists and the author in his preface makes it clear that he has had the examination syllabus of the Institute of Medical Laboratory Technology in mind while writing. Nevertheless, he hopes that the "book will also be of use to those wishing to learn or practice histopathology or histology—such as students of biology, physiology or medicine". Whilst this is the ideal bench book for serious students of histopathological technique, the contents are for the most part too specialised to appeal to the average medical student.

As chief technician at the Westminster Hospital Medical School, with many years' experience of both teaching and practising histopathological techniques, the author is well qualified to write a book of this kind. It is essentially a practical handbook and, as such, it gains enormously in value from Mr. Culling's personal experience of his subject. As Prof. R. J. V. Pulvertaft remarks in the foreword, "In this book he has set out the methods which he himself employs, with all the detail which makes the difference between success and failure".

The book is divided into six parts: Part I is a short introductory section on the cell, with an outline of the methods of examination of tissues and cells. Part 2 deals with fixation, processing and section cutting, and Part 3 (comprising nearly half the book) is concerned with staining methods and mountants. Part 4, on "Special Procedures", contains short chapters on Autoradiography, Vital Staining, Micro-incineration and Injection Techniques. Part 5 deals adequately with Museum Technique, and Part 6 on "The Microscope" gives a very valuable account of the principles of microscopy and the types of instrument now in general use.

The arrangement of the book is good, and it is clearly written, although in one or two parts of the text which deal with theory rather than practice, clarity has been sacrificed in the cause of brevity. The illustrations are well chosen and produced, and the book contains some useful tables. A few printing errors have been found—the legends for figure 32 (g) and 32 (h) have been transposed; an asterisk has been omitted before the footnote on p. 215; the name Perenyi has been mis-spelt in the index and the wrong page number has been given for the index reference to his decalcifying agent. As one who constantly suffers from having his name mis-spelt, your reviewer must also draw attention to the incorrect spelling of the following names: Tompsett (p. 350), McManus (p. 455) and Heiffer (Index p. 12). The name Kultschitsky has a different spelling in the text from that in the index. Some factual errors

have also been noted—on p. 31 it is stated that fixation in formol saline is usually complete in 24 hours at room temperature; on page 236 it is implied that plasma cells are of normal occurrence in serous membranes instead of mucous membranes, and it is no longer true to say that the function of mast cells is not known (p. 294). These are, however, minor faults in an excellent book which is certain to become a standard work for technologists in histopathology. The book is beautifully produced, the paper is good, the print clear, and the publishers claim that the binding is both waterproof and acid resistant. It cannot be denied, however, that the cost is high, having consideration for the type of person for whom this work is primarily intended.

G. STANSFELD.

THE SHOULDER by James Cyriax. Cassell.
Pp. 40. Price 5/-.

The various conditions occurring in and around about the shoulder joint are notorious both for their confused nomenclature and for their largely confectionary pathology. As a result, the effects of treatment at times not only variable but often disappointing.

In his new book "The Shoulder", Dr. Cyriax has assembled and described these conditions with a simplicity and clarity which will please and assist the General Practitioners and Physiotherapists, for whom it has been written. Due emphasis is laid upon accurate diagnosis, and the appropriate treatment is concisely defined.

Nonetheless, there remain those time-honoured terms such as adhesions, chronic bursitis, contracture of the costo-coracoid fascia and so on, terms which appeal to the imagination but which are difficult to demonstrate to the academic eye. Thus, without the advantage of a convincing pathology with which to incriminate these structures, it still remains difficult to be impressed by the therapeutic measures which are applied to them.

R. C. FARROW.

ANAESTHESIA FOR NURSES. Eric Goodwin.
Published John Wright & Sons, Ltd. Price

The scope of this little book is wider than its title implies, and covers in outline the management of many types of patient before operation, as well as the methods of administering anaesthetics, the care of the unconscious patient, the complications to avoid, and a glossary of drugs and instruments in use. There is a brief chapter on the anatomy and physiology of respiration as it affects anaesthetic techniques, and a practical section on the causes and avoidance of anaesthetic explosions. The successful management of the

infusion is rightly deemed to be a part of post-anaesthetic care, and methods of ensuring that compatible blood is used are described.

It would be better to give the approved than the proprietary names of drugs, and the description of bronchopneumonia on page 12 appears to apply to lobar collapse. All views expressed are modern and sensible, except for the suggestion on page 31 that the pharynx of an unconscious patient may be mopped out using swabs held in the fingers.

W.E.H.

AIDS TO MATERIA MEDICA FOR NURSES

by A. E. Squibbs. Baillière, Tindall & Cox.
Price 8s. 6d.

A preliminary sample of the index to find how up to date the revision of this edition has been is reassuring. On reading the book this impression is confirmed; a very thorough review has been made.

Approved names for drugs have been used throughout, and dosage is given primarily in metric measure. Latin has disappeared from the titles, and it is to be hoped that this will be better received by nurses than was the effort in this direction by the editors of the National Formulary. It would be sad to see this elegant language falling into disuse, if it were always used elegantly, but it is ruthlessly abused and abbreviated and nurses are probably well advised to use English.

Miss Squibbs is among the best known and best liked of nursing teachers today and I wish her every success with this new edition.

W. E. HECTOR.

PSYCHOLOGY AND PSYCHOLOGICAL MEDICINE FOR NURSES by Portia Holman. Heinemann. Price 10s. 6d.

Once upon a time nurses and doctors were alleged to think about "cases", and were exhorted to consider not diseases but patients. Now we have moved on to a different stage, and are asked to think about our clients not as patients but as people. The people whom we look after have been moulded by the pressure of events and the weight of their inheritance into their present pattern, which will profoundly affect their reactions to illness, and often even decide what that illness is to be. It is this attitude which Dr. Holman's book describes.

The biggest part of the book is taken up by a description of normal psychological development from birth to old age, and Dr. Holman manages to avoid suggesting as so many psychologists do, that nothing very interesting or important happens after the age of 5. The section on mental illness is very brief, and even for the nurse in general training does scant justice to the branch of medicine which occupies most beds in this country. Accuracy is sometimes sacrificed to brevity, as here: "Paranoid patients suffer from what are known as delusions of grandeur".

The final section describes the reactions of some patients to illness. The whole book is written simply and avoids technical obscurity. If the facts of Freudian psychology are stated in their extreme form, student nurses who have little time to study them tend to reject them totally and to abandon interest in the subject. Here they can see mental life as a developing process, in which illness may be an incident determined by the patient's past, and one which will influence his future.

W. E. HECTOR.

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Dr. Cullinan J. Q. Creightmore
Dr. Spence J. B. Nichols
Dr. Bodley Scott C. F. Allenby
Dr. Scowen M. A. Newton
Mr. Hume L. J. Chalcstrey
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A. M. M. Plumptre

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Eye Dept. M. A. Bedford
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Anaesthetics E. Clissold
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Orthopaedic Dept. N. J. C. Grant
at Hill End C. S. Goodwin
" " " M. M. McKerrrow
Thoracic Dept. D. H. Black
N. E. C. Coltart
Neurosurgical Dept. H. V. Blake
J. A. McKinna

EXAMINATION RESULTS

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Primary Fellowship Examination — November 1957

Harris, W. G.

Final Fellowship Examination — November 1957

Winstone, N. E. Gracey, L. R. H.
Griffith, A. N. * Ross, H. B.
Mehta, J. S. Blacklock, N. J.
* in Otolaryngology.

Part I

Al-Adwani,	Farrow, L. H.
A. R. M.	Martin, J.
Cocker, W. J. P.	Tabor, A. S.
Farren, P.	White, S. J.
Marks, A. P.	Charlton, C. A. C.
Simpson, R. I. D.	Ellison, A. J. H.
White, R. G.	Fenn, P. J.
Bench, J. T.	Norris, P. L.
Dale, C. C. H.	Thwaites, J. M.

SOCIETY OF APOTHECARIES

Final Examination — November 1957

Midwifery — Casson, A. J.

Part II

Chinery, A. R. O.	Lewis, J. H.
Tallack, J. S. T.	Marston, M. S.

UNIVERSITY OF LONDON

Final M.B., B.S. — October 1957

Hinton, J., honours in medicine.
Alade, R. B. Sutton, W. K.
Coakey, M. C. Vyle, E. A.
Hackett, M. E. J. Williams, J. C. L.
Laidlaw, C. D'A. Badley, B. W. D.
Major, V. T. D. H. Ellison, J. A.
Richings, J. C. H.
Hall, F. G. Grasset-Molloy,
Long, J. D. N. G. J. M.
Rowswell, E. F. D. Hawkes, P. H. R.
Pidcock, B. M. H. McKerrow, M. M.
Taggart, P. I. Plumptre, A. M. M.
Ware, J. M. Stuart, I. M.
Woolf, A. J. N. Visick, R. H.
Billardis, D. G. Watts, N. M.

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